YEAS (53)		NAYS (47)		NOT VOTING (0)	
Republicans (53 or 96%)	**Democrats (0 or 0%)**	**Republicans (2 or 4%)**	**Democrats (45 or 100%)**	**Republicans (0)**	**Democrats (0)**
Abraham					
Allard					
Ashcroft					
Bennett					
Bond					
Brownback					
Bunning					
Burns					
Campbell					
Cochran					
Collins					
Coverdell					
Craig					
Crapo					
DeWine					
Domenici					

EXPLANATION OF ABSENCE:
1—Official Business
2—Necessarily Absent
3—Illness
4—Other

SYMBOLS:
AY—Announced Yea
AN—Announced Nay
PY—Paired Yea
PN—Paired Nay

● health plans that provide prescription drugs through a formulary will be required to ensure the participation of physicians and pharmacists in developing and reviewing that formulary; plans will also be required to provide for exceptions from the formulary limitation when a non-formulary alternative is necessary and appropriate.

● Specialists: health plans will be required to ensure that patients have timely access to specialty health care providers appropriate to the patient's condition and age; plans will not be allowed to require authorizations for such access unless those authorizations provide for an appropriate number of referrals; see vote No. 207; for related debate, see vote No. 205.

● "Gag" rules: plans will be prohibited from including provisions in providers' contracts that restrict their right to communica te with their patients about treatment options and will otherwise be prohibited from attempting to impose such restrictions.

● Behavioral health services: plans that offer behavioral health services will be prohibited from barring a participant from self-paying for behavioral health care services.

● Clinical trials: plans will be required to provide coverage of routine patient costs for cancer clinical trials sponsored by the National Institutes of Health, the Department of Veterans Affairs, or the Defense Department; see vote No. 208.

● Provider nondiscrimination: to the extent necessary to meet the needs of their enrollees, plans will be prohibited from discriminating, based solely on licensure, against any provider's participation in their networks; see vote No. 208.

Grievances and appeals for all group health plans (federally regulated and State regulated)

● Grievances and appeals processes will be established for providers and patients to appeal denials of proposed treatments based on determinations that the proposed treatments are not medically necessary and appropriate or are experimental; both internal and external appeals processes will be established; strict timetables will be followed to resolve disputes, with expedited timetables to be followed to resolve disputes when the patient's life or health is jeopardized; internal and external appeals will be decided by health care providers with expertise, including age-appropriate expertise, in the specialty areas involved (for example, if a dispute is about a proposed cancer treatment for a child, a pediatric oncologist will conduct the review).

● Independent external review process details: an external review may be sought for an adverse coverage decision based on a medical necessity and appropriateness determination or on a determination regarding the experimental nature of a proposed treatment if in either case the amounts involved are above a significant financial threshold or if the enrollee's health will be jeopardized if treatment is denied; an independent external entity will have to be certified by the Federal Government or by a State government; a health plan will pick a certified external review entity for a review, and the entity then will select an independent reviewer to conduct the review; specific, short time frames will apply to the selection of an entity and reviewer and to the provision of all case information to that reviewer; the reviewer will be required to consider appropriate and available information, including evidence offered by the patient (who will have a right to present evidence) and the patient's physician, generally accepted medical practice and expert opinion, peer-reviewed literature, and the plan's evidence-based criteria and clinical practice guidelines; the reviewer will be permitted to set a deadline for treatment to begin, and, if a health plan does not provide the treatment, the patient will be permitted to begin receiving the treatment from any provider at the plan's expense, and the plan will be fined $10,000, payable to the patient; if a patient loses an external appeal, current rights to sue will still apply; see vote Nos. 199 and 208.

Reform of tax laws on health care

● Health insurance costs for the self-employed: health insurance costs for self-employed Americans will be made fully deductible (deductibility is currently being phased in; 21.3 million Americans are in families headed by self-employed entrepreneurs, and one-fourth of those families cannot afford any health insurance; this provision will give self-employed Americans the same tax benefits that currently apply to employer-provided health insurance); see vote No. 202; for related debate, see vote No. 198.

● Medical savings accounts (MSAs): MSAs are accounts in which individuals save money to pay for normal medical expenses; MSA holders purchase very high deductible insurance policies to cover catastrophic medical expenses; contributions to MSAs are tax deductible and withdrawals for medical expenses are tax free; MSAs are permitted under current law only under a demonstration program that limits eligibility for MSAs to self-employed Americans and workers in companies of 50 or fewer employees; this bill will amend limitations on the terms under which MSAs may be structured, and eligibility for starting MSAs will be expanded to all Americans; more than one-third of the individuals who have started MSAs under the current program previously were uninsured, which indicates that expanding eligibility for opening accounts and loosening the restrictions on their structure may significantly reduce the number of uninsured Americans.

Other provisions

● All group health plans will be required to provide a wide range of comparative information about health insurance coverage, such as descriptions of their networks, cost-sharing information, and contracts.

● All group health plans will be required to cover hospital stays for the treatment of breast cancer if the patients and doctors believe such stays are required; health plans will ensure that full coverage is provided for secondary consultations by specialists in the appropriate medical fields to confirm or refute cancer diagnoses; health plans will be prohibited from providing incentives or penalties in order to limit hospital stays for breast cancer treatment or to limit secondary consultations on cancer diagnoses; see vote No. 203; for related debate, see vote No. 198.

● Genetic information: all group health plans and individual health plans will be prohibited from denying coverage, or adjusting

premiums or rates, based on "predictive genetic information." "Predictive genetic information" will be defined to include an individual's genetic tests, genetic tests of family members, and information about family medical history.

● The Agency for Health Care Policy and Research will be redesignated as the Agency for Healthcare Research and Quality and will have its mission changed to encourage overall improvement of quality in the Nation's health care systems; it will facilitate state-of-the-art information systems, support primary care research, conduct technology assessments, and coordinate the Federal Government's own quality improvement efforts.

NOTE: Immediately prior to final passage, the Senate adopted a Lott/Nickles substitute amendment by voice vote.

Those favoring final passage contended:

The debate on this bill has been contentious, constructive, and comprehensive. Clear party differences have been drawn, but so too have areas on which there is common agreement. Both sides have been working diligently on this issue for several years and have a clear understanding of the nature of the problems in managed health care and are committed to enacting those solutions which they believe will work. Those of us on the Republican side of the aisle were determined to provide patient protections without increasing health insurance costs for all Americans and making it completely unaffordable for many Americans. With this bill, we have succeeded. The Congressional Budget Office has found that this bill will increase premiums by less than 1 percent. Further, that premium increase will not lead to a net loss in insurance coverage, because we have also added MSA tax benefits and tax benefits for the self-employed that will make health insurance more affordable for everyone.

The MSA tax benefits, in fact, may well be the most important part of this bill, because they will empower individuals. They will let individuals control their own health care accounts, instead of having their insurance tied to their employers. Problems of people losing their insurance when they change employers (that problem accounts for most of the people who do not have insurance) will be gone if people switch their health care to MSAs, and problems of HMOs denying treatment will also disappear because individuals, not HMOs, will be in charge of deciding which treatments will be covered. We understand that most of our Democratic colleagues are frightened at the idea of the American people making their own health care choices; Democrats pretty much invented managed care, and their ultimate dream, as embodied in the 1993 Clinton health plan, is still to force every American into one giant HMO run by the Federal Government.

In the final analysis, a bipartisan agreement was not reached because both parties have clear differences on the direction in which they want health care to go in America. Democrats favor centralized, government-controlled health care; Republicans want to give individuals as much control over their own health care as is possible. Still, we do not believe a compromise solution is out of reach. Patient protections, especially for Americans in federally insured group health plans, clearly need to be passed. We pledge to continue working with our colleagues to try to find a compromise solution.

Those opposing final passage contended:

Argument 1:

We thank our Republican colleagues for finally agreeing to fair terms under which we could debate this issue, and we agree that the debate has been constructive. Unfortunately, we must oppose this bill because our colleagues have been totally unwilling to compromise. On issue after issue, they insisted on passing provisions that protected insurance company profits to the detriment of Americans in need of health care coverage. Still, we are very hopeful that this bill will eventually be enacted. The House of Representatives has yet to consider the issue, and we have reason to believe that Republican Members in the House are more amenable to compromise. If we get to conference on this bill, we believe it may be possible to enter negotiations with the House and with the White House that will result in a true, bipartisan bill that everyone can support. For now, we must vote against final passage.

Argument 2:

Some of us who are Democrats add that we believe that both sides demonstrated an unwillingness to compromise on the provisions of their respective bills. The Republican bill did not go far enough, the Democratic bill went too far, particularly in its provisions on suing insurance companies and employers. We hope that both sides will put partisanship aside and work out a fair compromise. This Republican bill, though, will not go far enough, and on that basis it should be rejected.